Commentary

Have Physicians Abdicated Their Role?

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Despite enactment of progressive living will legislation in Hawaii and elsewhere, it is evident that the percentage of patients who have signed living wills has not increased significantly in the ensuing years. The reasons for this are many, but most of the blame can be laid on practicing physicians who have been unable to raise and pursue this delicate subject with their individual patients.[1-2]

The extensive mandated living will questionnaires required of hospital admitting offices in order to admit patients are more burdensome than helpful: They merely document the existence or nonexistence of a living will, but do not encourage patients to consider signing one, thereby adding to the already onerous paperwork required for admission. Even if they were so encouraged, elderly patients in the throes of life-threatening illnesses are usually in no condition to give the necessary thought required to make this critical determination on short notice in a tumultuous environment.

As a result of the failure of these well-meant legal attempts to deal with medical futility, we find ourselves still in the dilemma of caring for terminally or catastrophically ill patients of advanced age in intensive care settings. We still spend billions a year of our dwindling medical dollars and resources on patients who should have been allowed to succumb peacefully to overwhelming diseases. Any one of us can walk into our critical units and find them filled with post-resuscitated 70 and 80 year olds on ventilators awaiting bypasses or dialysis or more cardioversions before they die.

Despite the ample literature on medical futility in these settings, it has become almost passe´ to think about, let alone discuss, this catastrophe of technologically induced agony, which sometimes borders on torture. As physicians, we know that the vast majority of patients will never survive in any meaningful way after our *interventions*, and yet we seem incapable of doing anything about it. We are all guilty of turning our heads, literally and figuratively.

Instead, our current practice is to rationally "discuss the code status" with the family, striving to explain to them in an even-handed, almost apologetic way, the intricacies of the case, and let them "think about it" and come to a "consensus." We leave what amounts to a clearly clinical decision entirely up to highly stressed family members who are not in any way knowledgeable in this scientifically complex area, let alone psychologically prepared to take on this grave moral responsibility. We do this ostensibly because we are fearful of legal repercussions if we do not offer *to do everything* to save the patient, even though we know that anything we do will be futile: unless we "cover ourselves," we could be sued.

We must ask whether or not we have abdicated our own field of expertise to lawyers, courts, administrators and the public. We remain silent in this area instead of exerting our considerable power as "experts" in the area of medical futility. It is my contention that the failure of legal means to satisfactorily address this problem throws the ball back into medicine's court. As medical professionals with a solid scientific rationale, we must empower ourselves to become more proactive in our care of the elderly.

Instead of going hat in hand to the family of the 82-year-old woman admitted to us with congestive heart failure and a massive stroke and asking them whether they want us to resuscitate her if her heart stops beating or she stops breathing, why can't we, as knowledgeable and caring physicians, tell them that we are doing everything for her that we can, but strongly suggest to them that in our medical opinion, *heroic measures* would be fruitless?

We can assure them that we will do everything in our power to prevent them from getting to that stage where such measures would be needed (mention intravenous fluids, antibiotics, blood thinners, oxygen, etc). But mustn't we also go on to say that if she does stop breathing or her heart stops, we do not think, in our clinical judgment (emphasis "in *my* experience"), that drastic measures such as chest compressions ("their bones are fragile and they almost always break when we do this"), cardioversion ("even if she's in deep coma, this is the one thing that she will definitely feel"), or intubation ("its very uncomfortable for her to have this large tube in her windpipe") or other painful, invasive procedures are *medically* warranted. "They won't help her in the long run, and they will make the short time that she survives an extremely painful and unpleasant experience just before she dies."

This graphic use of language is not cold, cruel, or manipulative, but is truthful and realistic. We do not need to mince words. We are painting a vivid picture for the family so they can understand more easily our reasoning for withholding futile and torturous applications of technology, which are not to be confused with medically useful and comfort-inducing therapies we have already told them (and can tell them again) we will give her. Such a proactive presentation sets the stage for the physician to say something like, "...and so with your permission, I'm going to tell the nurses to do everything for her but those very painful and invasive things that I have told you about, and if you have any questions (don't say *objections*), please let me know." After this presentation, very few family members are going to have the heartlessness or selfishness to demand that their mother or wife be a full code.

It is our prerogative as well as our responsibility to our elderly patients and society to make these decisions: We are the only ones who have the expertise. It is not paternalism, it is professionalism. Just as when we order antibiotics, IVs or dialysis, we are acting on our knowledge and experience to deliver the best care possible, which in this case is *primum non nocere*. We must start taking control of these clinical situations, for there appears to be no other remedies for the malady of medical futility on the horizon, and as we get better with our technology at suspending death, the problem will get worse.

In the past two years, I have found this proactive approach to obtaining no-code orders to be effective, humane, and acceptable to patients' families in almost all instances, and I have had almost no geriatric intensive care nightmares. The approach

must be individualized in each case and must be practiced, since it initially feels somewhat awkward for us to be speaking in this manner to patients' families. However, it is medically and ethically correct, and I find it a much more satisfying form of medical practice than performing as some sort of medical technician in the service of a legal system that has failed to solve the question of medical futility.

References

1. Stelter KL, Elliott BA, Bruno CA. Living will completion in older adults. *Arch Intern Med.* 1992;152;5:954-9.
2. Sugarman J, Weinberger M, Samsa G. Factors associated with veterans' decisions about living wills. *Arch Intern Med.* 1992:152;2:343-7.

Ethical Issues—Physicians and Managed Care

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Health care delivery, a long-standing cottage industry, has undergone change during the past five years. Large for-profit corporations have gained increasing market share in various parts of the country and Hawaii is not immune to this phenomenon. The payers of health care, business, labor and government have determined that costs have been escalating and management is absolutely essential for economic survival. As health care costs have risen and calls for more cost-conscious health care have been made, health insurers increasingly have adopted principles of managed care. There is no assurance that high levels of quality will be maintained. Some managed care programs have developed so that profit is the only motive and physicians have been forced to ratchet-down services. Some corporate heads have made large personal profits while decreasing patient care and physician reimbursement. Insurance companies have purchased physician practices or entered into very restrictive managed care contracts with physicians. A tremendous threat exists to the sanctity of the doctor-patient relationship.

Hawaii has a unique system because of the Pre-paid Health Insurance Act. Managed care has been in Hawaii for a long time. The competition between managed care and traditional fee for service has maintained high quality, and costs have been controlled, but the rise of medical inflation has not. Hawaii has large populations of Medicaid, Medicare, state and county employees, federal employees, hotel workers, large businesses, and labors unions. These large groups can be shifted into more restrictive managed care with relative ease. There is a concern that Hawaii will attract a ruthless Mainland-type of company seeking large market shares, significant penetration of the marketplace, and will be concerned only with the bottom line of profits without concern for quality of care.

Managed care plans use a number of techniques, some are directed at subscribers, some at physicians, by creating economies of scale, by coordinating care among physicians and hospitals, mandating the use of guidelines or parameters of care and establishing advanced information systems that provide an improved basis on which to measure quality and efficiency.

Managed care plans can constrain the costs of participating physicians' practices in several ways. The plan could restrict physicians from performing certain procedures, or from ordering certain medications or diagnostic tests. Managed care plans use programs of utilization review to detect what they consider unnecessarily costly practice patterns. Sometimes these programs become harassing, intimidating, and deceptive. They can encourage physicians to make cost-conscious treatment decisions through the use of financial incentives. Some plans pay bonuses to physicians, with the amount of the bonus increasing as the plan's expenditures for patient care decrease.

While efforts to contain costs are critical and many of the approaches of managed care have an impact, managed care can compromise the quality and integrity of the patient-physician relationship and reduce the quality of care received by patients. In particular, by creating conflicting loyalties for the physician, some of the managed care techniques can undermine the physician's fundamental obligation to serve as a patient advocate. Moreover, managed care can withhold appropriate diagnostic procedures or treatment modalities from the patient.

The Patient-Physician Relationship

The foundation of the doctor-patient relationship is based on the trust that physicians are dedicated first and foremost to serving the needs of their patients. It is trust that enables patients to communicate private information and to place their health and their lives in the hands of physicians. Patients trust that physicians will do everything in their power to help them. No other segment of the health system is charged with the responsibility of advocating for patients, and no other segment can be expected to reasonably assume the responsibility conscientiously. Physicians who care for patients directly are in the best position to know patients' interests and can advocate within the health care system for patients' needs.

Ethical Concerns

Ethical concerns with managed care arise because of at least two conflicting loyalties for the physician. First, physicians are expected to balance the interests of their patients with the interests of other patients. Second, managed care can place the needs of patients in conflict with the financial interests of the physicians. Managed care plans use bonuses and fee withholding to make physicians cost conscious. As a result, when physicians are deciding whether to order a test, they will recognize that it could have an adverse effect on their incomes.

Conflicts Among Patients

Some cost containment can be achieved by eliminating waste and improving efficiency. Cost containment is being achieved by limiting the availability of tests or procedures that offer only small or uncertain benefit, or that provide a likely benefit but at great expense. Because managed care plans generally work